



**AGENCY OF HUMAN SERVICES**  
**DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING**

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

October 17, 2023

Ms. Darshane Campbell, Manager  
Single Steps  
62 Barre Street  
Montpelier, VT 05602-3508

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 28, 2023**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink, appearing to read "Carolyn Scott".

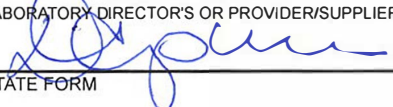
Carolyn Scott, LMHC, M.S.  
State long Term Care Manager

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments:  On 7/24/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey with additional information provided by the facility on 7/25/23 and 7/28/23. The following regulatory deficiencies were identified:	R100		
R128 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.5 General Care</p> <p>5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure medications are administered according to physician's orders for one applicable resident. Findings include:</p> <p>1. Per record review Resident #6's Physician's Admission Statement signed by the physician on 7/13/23, included an order for Methocarbamol 500 mg three times daily for pain with a note in different handwriting indicating this order was added on 7/14/23.</p> <p>Resident #6's Medication Administration Record (MAR) for July 2023 listed Methocarbamol 50 mg four times a day beginning on 7/13/23 indicating a different dose and frequency of administration than the Physician's Admission Statement. The order on the MAR was changed to three times daily with a handwritten note that says "3 x/day", a single line drawn through the 4 PM dose, and no</p>	R128		

Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 9/8/2023 Program Coordinator (Single Steps)	(X6) DATE
---	---	-----------

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R128	<p>Continued From page 1</p> <p>staff signatures after 7/19/23. The typed instructions to administer the medication four times a day were not removed from the MAR.</p> <p>A copy of Resident #6's Resident Profile from the Designated Agency that manages the home included a typed order for Methacarbamol 500 mg four times daily, which was changed with a line drawn through the word THREE and the number 4 handwritten beside the order, indicating the medication was intended to be given 3 times daily. There is no documentation of a signed physician's order clarifying if the Methacarbamol was to be given 3 or 4 times daily, and the Manager was not aware of the incorrect dose of 50 mg listed on the MAR.</p> <p>2. Resident #6's Physician's Admission Statement signed by the physician on 7/13/23 listed Carvedilol 3.125 mg Two tablets twice daily for blood pressure. Resident #6's Medication Administration Record (MAR) for July 2023 and Resident Profile from the designated agency that manages the home both list Carvedilol 12.5 mg Once daily. The total daily dose was the same for all orders, however the scheduled doses and frequency of administration were not consistent. There is no documentation of a signed physician's order clarifying orders for Carvedilol.</p> <p>At 4:00 PM on 7/24/23 the Manager confirmed medications were not administered as ordered for Resident #6.</p>	R128		
R144 SS=E	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c.(1)</p>	R144		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R144	<p>Continued From page 2</p> <p>Complete an assessment of the resident in accordance with section 5.7;</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to complete Resident Assessments for 2 applicable residents (Resident #2 and #5) in accordance with section 5.7 of the Vermont Residential Care Home Licensing Regulations effective October 3, 2000. Findings include:</p> <p>Per record review Resident #2 was admitted to the facility on 5/17/22 and an annual reassessment for 2023 was not on file and available for review for Resident #2. His/her annual reassessment was due in May of 2023.</p> <p>Per record review Resident #5 was admitted to the facility on 4/10/23. The admission assessment for Resident #5 on file was dated 4/14/23, however the assessment was not signed as completed by the RN indicating the assessment was completed with the oversight of a registered nurse and verifying the accuracy of the assessment.</p> <p>On the afternoon of 7/24/23 the Manager confirmed the Resident Assessments for Residents #2 and #5 were not completed as required.</p>	R144		
R145 SS=D	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.9.c (2)</p>	R145		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	<p>Continued From page 3</p> <p>Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the development of a plan of care that addresses the medical needs of 1 applicable resident (Resident #5), and to develop a plan of care for one applicable resident (Resident #6). Findings include:</p> <p>1. Per record review Resident #5 has a respiratory conditions including Asthma and Chronic Obstructive Pulmonary Disease (COPD), pain due to back injury, chronic constipation, and risk of a cardiac event due to history of stroke. At 2:46 PM the Manager confirmed Resident #5's Plan of Care does not describe care and services related to these conditions.</p> <p>2. Per record review Resident #6 was admitted to the facility on 7/13/23 with diagnoses including Major Depressive Disorder, chronic substance abuse and dependence issues, skin conditions including rashes, and frequent periods of anxiety. At 4:15 PM the Manager confirmed a plan of care had not yet been developed for Resident #6 after emergency admission to the home following loss of housing due to flooding.</p>	R145		
R162 SS=E	V. RESIDENT CARE AND HOME SERVICES	R162		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R162	<p>Continued From page 4</p> <p>5.10 Medication Management</p> <p>5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure signed orders for all medications administered to 2 applicable residents (Residents #2 and #5). Findings include:</p> <p>During the course of the survey the Manager was requested to provide documentation of physician's signed orders for the following medications.</p> <p>1. For Resident #2: Saline Nasal Spray, Pantoprazole 40 mg tabs, Hydroxyzine 50 mg tabs, and Clonidine 0.1 mg tabs.</p> <p>2. For Resident #5: Pantoprazole 40 mg tabs, Aspirin 81 mg tabs, Clonazepam 2 mg tabs, Carvedilol 12.5 mg tabs, Atorvastatin 40 mg tabs, Zolpidem 10 mg tabs, and Docusate Sodium.</p> <p>At 2:39 PM on 7/24/23 the Manager confirmed signed medications orders for the following medications listed on the resident's July 2023 Medication Administration Records were not on file and available for review.</p>	R162		
R165 SS=F	V. RESIDENT CARE AND HOME SERVICES	R165		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R165	<p>Continued From page 5</p> <p>5.10 Medication Management</p> <p>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</p> <p>(3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for:</p> <ul style="list-style-type: none"> <li>i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects;</li> <li>ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications;</li> <li>iii. Assessing the resident's condition and the need for any changes in medications; and</li> </ul> <p>Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Residential Care Home (RCH) failed to ensure the Registered Nurse (RN) who assumes the responsibility for staff performance in the administration of medications had re-delegated staff as required when a change occurred in nursing staff. Findings include:</p> <p>At 4:46 PM on 7/24/23 the RCH Manager confirmed the RN identified responsible RN for medication delegation since 6/6/23 had not re-delegated the present staff responsible for administration of medications at the home.</p>	R165		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R165	Continued From page 6  Although past RNs had delegated staff there must be a re-delegation under the newly assigned RN.  Per review of documentation provided by the Manager on 7/28/23 the RN completed medication delegation training for 8 designated staff on 7/25/23, the day following the relicensure survey.	R165		
R167 SS=F	V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the nurse failed to develop plans for the administration of PRN (as needed) psychoactive medications which describe the side effects for which the staff must monitor for 4 out of 4	R167		



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

**SINGLE STEPS**

**62 BARRE STREET  
MONTPELIER, VT 05602**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R167	Continued From page 7  applicable residents (Residents #1, #2, #3 and #4). Findings include:  Per record review Resident #1, #2, #3 and #4 are prescribed psychoactive PRN medications. At 12:15 PM on 7/24/23 the Manager confirmed the psychoactive PRN plans developed for the administration of these medications fail to describe the side effects staff must monitor for.	R167		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:  (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.	R179		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 4 out of 5 sampled staff completed all required yearly trainings. Findings include:</p> <p>Per review of staff training records: * 1 staff did not complete any required yearly trainings</p> <p>* 1 staff did not complete trainings in Resident's Rights; Fire Safety and Emergency Preparedness; Resident Emergency Response and First Aid; Mandatory Reporting of Abuse, Neglect, and Exploitation; and infection Control Measures</p> <p>* 1 staff completed only the required General Care and Supervision training</p> <p>*1 staff did not complete First Aid training</p> <p>The Manager confirmed 4 out of 5 sampled staff did not complete all required yearly trainings during the previous year at 11:53 AM on 7/24/23.</p>	R179		
R234 SS=C	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.1.a.(3) The current week's regular and therapeutic menu shall be posted in a public place for residents and other interested parties.</p> <p>This REQUIREMENT is not met as evidenced by: Based on on observation and staff interview there</p>	R234		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R234	Continued From page 9  was a failure to post a weekly menu in a public place. Findings include:  During the facility tour commencing at 10:05 AM on 7/24/23 it was observed that a menu was not posted in the home. At 11:23 AM on 7/24/23 the Manager confirmed the weekly menu was not posted and available for review.	R234		
R242 SS=F	VII. NUTRITION AND FOOD SERVICES  7.1.c. (1)  Each home shall provide residents with three nutritionally balanced, attractive and satisfying meals in accordance with these regulations. Meals shall be served at appropriate temperature and at normal meal hours. Texture modifications will be accommodated as needed.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide three meals per day in accordance with regulations for all residents. Findings include:  During the facility tour commencing at 10:05 AM on 7/24/23 residents were observed making their own breakfast. Per interview with the staff conducting the tour confirmed residents of the home are responsible for making their own breakfast and lunch daily. At 11:23 AM on 7/24/23 the Manager confirmed only the dinner meal is prepared by staff for the residents of the home.	R242		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247  R247 SS=F	<p>Continued From page 10</p> <p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.2 Food Safety and Sanitation</p> <p>7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable foods and drinks are labeled and dated. Findings include:</p> <p>During the facility tour commencing at 10:05 AM on 7/24/23 undated, unlabeled, and unwrapped perishable food items were observed to be stored in the kitchen of the home. The kitchen refrigerator contained opened undated perishable items including containers of juice, milk and oat milk; jars of discolored spaghetti sauce and moldy applesauce; and numerous jars of condiments and sauces. There were unwrapped bags of sliced deli meats and cheeses, some which were expired including sell by dates of 6/20/23 and 7/4/23. A drawer in the fridge contained opened undated bags of carrots and discolored lettuce; and there was an unknown liquid in the corner of one drawer with a small piece of unwrapped bacon in the liquid. There were 3 unlabeled unated containers of prepared foods in the refrigerator freezer contained a hamburger patty without packaging and 2 containers of unlabeled undated prepared foods. There was an unwrapped undated stick of butter on the counter, which staff conducting the tour confirmed to be the customary practice.</p>	R247  R247		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R247	Continued From page 11	R247		
R258 SS=D	<p>VII. NUTRITION AND FOOD SERVICES</p> <p>7.3 Food Storage and Equipment</p> <p>7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure the trash in the kitchen area is placed in containers with covers. Finding include:</p> <p>During the facility tour commencing at 10:05 AM on 7/24/23 both trash cans in the kitchen were observed to be without lids. At 11:23 AM on 7/24/23 the Manager confirmed the trash was stored in cans for which there were no lids.</p>	R258		
R266 SS=F	<p>IX. PHYSICAL PLANT</p> <p>9.1 Environment</p> <p>9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.</p>	R266		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to provide care in a safe, sanitary, functional, homelike environment. Findings include:</p> <p>During the facility tour commencing at 10:05 AM on 7/24/23 the following environmental concerns were observed:</p> <ol style="list-style-type: none"> <li>1. The main refrigerator, oven and countertops had food and beverage spills on surfaces and were in need of cleaning. There was an infestation of fruit flies observed in the kitchen which appeared to originate from the compost bin stored on the countertop. The kitchen fire extinguisher was stored on the floor tucked into the corner created by a half wall at the side door entryway and the kitchen cabinets where it was not easy visible. A window along the ramp into the living room, which is an area open to the kitchen and dining areas, was observed to be without a screen.</li> <li>2. Containers of cleaning products and utility items were observed to be covering the landing at the top of the basement staircase, which impeded access to the staircase and created a potential trip hazard.</li> <li>3. A used toothbrush and a tube of SF 5000 Plus toothpaste, which is a prescribed medication containing higher amounts of fluoride than over the counter toothpaste, were observed to be stored on a shelf with food items in an unlocked and easily accessible cabinet in the dining room.</li> </ol> <p>At 11:23 AM on 7/24/23 the Manager confirmed</p>	R266		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>0153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/28/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>SINGLE STEPS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>62 BARRE STREET MONTPELIER, VT 05602</b>
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 13  the environmental concerns observed during the facility tour.	R266		
R311 SS=C	<p>X. PETS</p> <p>10.2.e Pet health records shall be maintained by the home and made available to the public.</p> <p>This REQUIREMENT is not met as evidenced by: There was a failure to ensure pet health records are maintained by the home and made available to the public. Findings include:</p> <p>Per observation there are three cats belonging to residents living at the home. At 1:20 PM the Program Manager confirmed there were no pet health records on file and available for review for 2 out of 3 of the cats living at the home, and the health records for the 3rd cat living at the home were not complete and up to date.</p>	R311		

Manager: Darshane` Campbell, [darshane.campbell@wcmhs.org](mailto:darshane.campbell@wcmhs.org), 802-229-4109

Facility: WCMHS- Single Steps

Plan of Correction for 7/28/23 Survey. Due: 8/30/23

**ID PREFIX TAG**

**Plan of Correction & Implementation and Completion date:**

<p>R128</p> <p>5.5.c General Care</p> <p>Accepted by Jo A Evans RN 9/11/23</p>	<p>Due to the flood that occurred in July, a client needing immediate support was admitted to Single Steps leaving little time to complete a full admission. Due to the emergent nature of the admission, several items were left incomplete or were missing.</p> <p>POC: During emergent admissions, Single Steps staff will ensure that all medications have been verified by all the professional prescribing parties.</p> <p>In this case, medications were verified, however, when medications arrived there were documentation errors with the medication list printed by Health Direct and the medication list we received.</p> <p>Staff will confirm the correct doses and times this resident takes their medications. The Program Nurse will review medication orders are correct on a yearly basis or as needed.</p> <p><b>Corrected:</b> Orders clarified 8/7/23</p>
<p>R144</p> <p>5.9.c (1) Resident Care and home services</p> <p>Accepted by Jo A Evans RN 9/11/23</p>	<p>Due to the change in Nursing personnel at this facility, the lack of the Nurses Assessment was a clerical oversight.</p> <p>POC: The Program Nurse will put these dates on a nursing calendar in the office in order to stay in compliance. The Program Manager will double check that this has been completed on a monthly basis. All assessments will be reviewed and signed for.</p> <p><b>To be completed: 9/1/23</b></p>
<p>R145</p> <p>5.9.c (2) Resident Care and home services</p> <p>Accepted by Jo A EvansRN 9/11/23</p>	<p>The Program Nurse will include a reference to any necessary "Special Care Procedures" in the existing treatment plans to address the physical diagnosis that some of our clients have. The Treatment plans will be updated on an on-going and as needed basis in order to keep them current and in compliance. The Program Nurse and Manager will review the treatment plans. The Program Manager will review treatment plans each month according to a calendar.</p> <p>Implemented immediately.</p>
<p>R162</p> <p>5.10.c. Medication management</p> <p>Accepted by Jo A Evans RN 9/11/23</p>	<p>The original written orders were not available for two residents as there was a transition in Nursing personnel. Since the review/survey ended, new orders were sent to each of the residents' Medical and Psychiatric providers for review and signatures. Going forward, original orders will be scanned in and put in the resident folder on the computer.</p> <p>Implemented: 8/1/23</p>
<p>R165</p> <p>5.10.d Medication Management</p> <p>Accepted by Jo A Evans RN 9/11/23</p>	<p>Medication administration training and delegation was held on 5/25/23 for Single Steps. The Program Nurse has access to the training materials. Records of training materials will be kept on site going forward with the Program Nurse's signature.</p> <p>To be implemented by 9/11/23</p>
<p>R167</p> <p>5.10.d Medication Management</p> <p>Accepted by Jo A Evans RN 9/11/23</p>	<p>When Staff are initially delegated, side effects are reviewed. The Program Nurse will ensure that a medication drug handbook is available and accessible for staff on site. Side effects for psychotropic PRNs will be added to the PRN documentation sheet and a space added for staff to indicate any side effects noticed.</p> <p>To be completed by: 10/1/23</p> <p>Type text here</p>



**I PREFIX TAG**

**Plan of Correction & Implementation and Completion date:**

<p>R179: 5.11 Staff Services <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>All staff will achieve 12 hours of required training, annually. Monthly training audits will occur for assigned training as well as in-person or hybrid trainings during staff meetings by the manager. Manager will ensure that these trainings are completed before Staff work one-on-one with residents. <b>Implementation: 7/25/23</b> (Staff to return completing trainings in a timely fashion)</p>
<p>R234: 7.1.a (3) Nutrition and Food Services <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>A Staff member has been appointed to complete and post a weekly meal schedule (menu). When said Staff member is absent, the manager will post the schedule. <b>Implemented: 8/1/23</b></p>
<p>R242: 7.1.c (1) Nutrition and Food Services <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>Staff will add meal planning to their daily schedules/routine. Staff will check in with each resident to come up with a breakfast and lunch plan for the day. There will be a variety of choices posted and Staff will make themselves present and available for assistance with preparation. When residents “opt in” with their signatures on the menu, Staff will prepare that meal. <b>Implemented: 8/1/23</b></p>
<p>R247: 7.2.b Food Safety and Sanitation <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>All food items will be properly labeled, dated and stored once it has been opened by both Staff and residents. Staff will add label checking to their daily routine. In addition, an assigned Staff will check weekly and dispose of expired and unlabeled food. <b>Implemented: 8/1/23</b></p>
<p>R258: 7.3 Food Storage and Equipment <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>Garbage cans with lids were brought from the basement to replace the garbage bins without lids. One more garbage bin lid has been ordered. <b>Completed: 7/25/23</b></p>
<p>R266: 9.1a Physical Plant</p>	<p>-Peer staff who complete the programs’ janitorial work will be given a task list to ensure nothing is overlooked in conjunction with staff who will add it to their daily list of tasks. Supervisor will check their work after each shift.  -A screen was put in the window by the agency’s maintenance staff who also put the Fire extinguisher on the wall. <b>Completed: 7/25/23</b></p>
<p>R266 cont. <small>Accepted by Jo A Evans RN 9/11/23</small></p>	<p>2. Cleaning materials were put on the shelves behind the locked door. Excess cleaning materials were put in the locked basement on <b>7/29/23</b>. A staff member has been assigned to check the basement landing and any unlocked cabinets for chemicals, remove them, and put them behind the locked basement. 3. Prescription toothpaste and toothbrush were placed back inside of the medication cabinet which remains locked on <b>7/25/23</b>.</p>
<p>R311 10.2.e Pets</p>	<p>Resident Referrals are now required to have all documentation attached, prior to admission including pet documentation. This requirement will be added to Staff’s admission checklist in order to confirm the retrieval of the necessary documents. Staff will work with the residents to retrieve updated vaccination records for the pets that live in the home. The manager will note on the calendar for the resident pets to be examined yearly by their veterinarians.</p>

Accepted by Jo A Evans RN 9/11/23

**To be completed: 9/1/23**